WOUND CARE:

Wound care is a major challenge to hospice nurses providing care to their hospice patients.

Because of the eventual debility of terminally ill patients, every hospice patient has the potential for major skin breakdown.

There are many reasons for risk, some of which may be:

*Poor nutrition
*Poor mobility
*Disease process
*Incontinence

More information can be found at The Wound, Ostomy and Continence Nurses Association (WOCN). Their website is www.wocn.org.

Another excellent resource is the National Pressure Ulcer Advisory Panel (NPUAP). Their website is www.npuap.org.

We want to speak with you today about the lack of documentation regarding wound care. This lack of documentation has lead to many deficiencies in the past.

We hope to share some of our insight with you today.

Each skin assessment must ACCURATELY document skin integrity. (USE EXAMPLES TO MAKE THIS POINT).

When a wound is found document:

- Location
- Size
- Drainage
- Amount of drainage
- Odor
- Stage
- Appearance of surrounding skin.

When multiple wounds are found be consistent in numbering the wounds from one visit to the next.

We would expect to see documentation of weekly wound measurements per standard of practice and agency policy and if multiple wounds, each wound must be measured and identified accurately.

When a stage 3 or stage 4 pressure ulcer heals that wound will ALWAYS be the same stage number when it reopens.

Nurses need to use consistency in numbering wounds and in documenting the same wound description at each visit. Deficiencies are frequently written because of confusing documentation. (USE EXAMPLES)

Remember you must have written physician orders. These orders must specify all steps of the wound care to be performed.

If you are going to instruct another person regarding wound care there must be a physician order. (Give example).

When using computer programs (and there are many good ones) be certain that you identify the exact wound and the exact treatment on EACH nursing visit.

IF pt/family or caregiver is responsible for wound care in between nursing visit you must document teaching and capability of the responsible person to provide the wound care.

This capability must be determined by <u>return</u> observation not just "verbalizes understanding."

The nurse will be expected to provide the wound care during visits in order to monitor the wound status. If for some reason, this is not done there must be clear documentation as to why.

We also would expect to see documentation that the nurse is monitoring wound care being completed by the responsible party in between nursing visits.

REMEMBER: A person residing in a nursing facility is entitled and should receive the same care as someone residing in a private residence.

Hospice nurses should perform at least weekly visual wound inspections/ wound care. If the nursing home staff does not allow anyone else to perform the wound care, the hospice nurse can at least observe one dressing change per week to see that the doctor's treatment orders are followed and results are satisfactory. Hospice is to manage the patient's care in the nursing home, and cannot do this by verbal reports of wound progress.